Vermont Department of Disabilities, Aging & Independent Living
Assisted Living Residence and Residential Care Home
COMPREHENSIVE RESIDENT ASSESSMENT

SECTION AA:

1. **Resident's NAME:** _____ 4. **Assessment Completion Date:** _____
2. **Facility NAME:** _____ 5. **Assessment Reference Date:** _____
3. **Admission Date:** _____
6. **Reason for Assessment:**

a. ❒Admission b. ❒Significant change c. ❒Annual reassessment d. ❒Other _____

SECTION A: DEMOGRAPHIC INFORMATION

1. Gender: a. ❒Female b. ❒Male
2. Birth Date: _____
3. Social Security #: _____
4. Medicare/Medicaid #: _____
5.Other Insurance: _____
6. Attending Physician: _____ # _____
7. Other Physician(s): _____ #_____
8. Primary Language: _____
9. Secondary Language: _____
10. Marital Status: a. ❒Married b. ❒Single c. ❒Divorced d. ❒Widowed e. ❒Civil Union
11. Previous Residence: a. ❒Private home or apartment b. ❒Assisted Living Residence c. ❒Senior housing d. ❒Residential Care Home e. ❒Nursing Home f. ❒Other: _____ 12. Admitted from hospital: a. ❒Yes b. ❒No
13. Name of contact person: _____ Relationship: _____
Address: _____ Work Phone: _____
Home Phone: _____ Other Phone: _____
14. Name of contact person: _____ Relationship: _____
Address: _____ Work Phone: _____
Home Phone: _____ Other Phone: _____

Name	Home Phone	Other Contact
a. Legal Guardian		
b. General Power of Attorney		
c. Representative Payee		
d. DPOA for Health Care		
e. Case Manager		

16. B. Check all that apply and obtain copy for resident record:
a. ❒Advanced Directives d. ❒Organ donation
b. ❒Do Not Resuscitate e. ❒Funeral arrangements
c. ❒Living Will f. ❒None of the above
17. List all allergies:
_____
18. Lifetime occupation(s):
_____
19. Religious preference: _____

20. List all hospitalizations since last full assessment. Include observation stays and emergency room visits. Attach additional sheets if necessary.

Date of Hospitalization: Date of Hospitalization:
Date of Return: Date of Return:

Date of Hospitalization: Date of Hospitalization:
Date of Return: Date of Return:

15. A. Does the resident have :(check all that apply)

RECORD STATUS IN LAST 7 DAYS, UNLESS OTHER TIME FRAME INDICATED

SECTION B: CUSTOMARY ROUTINE (Check all that apply. If all information UNKNOWN, check last box only.)

1. Cycle of Daily Events

a. ❒ Stays up late at night (after 9 p.m.) j. ❒ Restless, nightmares, disturbed sleep,
b. ❒ Naps regularly during day (at least 1 hour) increased awakenings.
c. ❒ Goes out 1+ days a week k. ❒ Usually attends church, temple, synagogue (etc.)
d. ❒ Stays busy with hobbies, reading, or fixed l. ❒ Daily animal companion/presence
daily routine m. ❒ Needs assistance to stay involved in activities
e. ❒ Spends most of time alone or watching TV n. ❒ In bedclothes much of the day
f. ❒ Moves independently indoors o. ❒ Wakens to toilet all or most nights (with appliances, if used) p. ❒ Has irregular bowel movement pattern
g. ❒ Use of tobacco products at least daily q. ❒ Showers for bathing
AM❒ PM❒
h. ❒ Unpleasant mood in AM or PM r. ❒ Tub Bath AM❒ PM❒
i. ❒ Use of alcoholic beverage at least weekly s. ❒ Sponge Bath AM❒ PM❒
t. ❒ UNKNOWN

2. Eating Patterns

a. ❒ Distinct food preferences c. ❒ Eats less than three meals per day.
b. ❒ Eats between meals all or most days d. ❒ NONE OF ABOVE

3. Family/Friend Involvement

A. How often is the resident visited by family or friends?
1. ❒Daily 2. ❒Weekly 3. ❒Monthly 4. ❒1-4 times a year 5. ❒Rarely or Never
(Ask the resident to answer B & C below)
B. Do you feel you have enough contact with family? 1. ❒Yes 2. ❒No 3. ❒Unable to answer
C. Do you feel you have enough contact with friends? 1. ❒Yes 2. ❒No 3. ❒Unable to answer

SECTION C: COGNITIVE PATTERNS

1. Memory Recall (what was learned or known)

A. Short-term memory OK: seems/appears to recall after 5 minutes. 1. ❒OK 2. ❒Problems
B. Long-term memory OK: seems/appears to recall long past. 1. ❒OK 2. ❒Problems

2. Cognitive Skills for Daily Decision-Making (Ability to manage daily life tasks)
a. ❒ Independent—decisions consistent/reasonable
b. ❒ Modified independence—some difficulty in new situations only
c. ❒ Moderately impaired—decision poor/cues/supervision required
d. ❒ Severely impaired—never/rarely makes decisions

3. Memory & use of information *(Please check the description that most accurately describes the resident's behavior)*
a. ❒ Remembers and uses information. Does not require directions or reminding from others.
b. ❒ Minimal difficulty remembering and using information. Requires direction and reminding from others 1 to 3 times per day. Follows simple instruction.
c. ❒ Difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
d. ❒ Cannot remember or use information.

4. Change in Cognitive Status *(Resident's cognitive status, skills, or abilities in the last 90 days or since the last assessment)*
a. 1. ❒No change 2. ❒Improved 3. ❒Deteriorated
b. Cognition varies over 24-hour period. 1. ❒Routinely 2. ❒Occasionally 3. ❒Never

SECTION D: COMMUNICATION/HEARING PATTERNS

1. Hearing
a. ❒ Hears adequately (normal talk, TV, phone)
b. ❒ Minimal difficulty (when not in quiet setting)
c. ❒ Hears in special situations only (*speaker has to adjust tonal quality and speak distinctly*)
d. ❒ Highly impaired (absence of usual hearing)
e. ❒ Hearing aid present and used
f. ❒ Hearing aid present and not used regularly
g. ❒ Other receptive techniques used (e.g. lip reading)
h. ❒ NONE OF ABOVE

2. Modes of Expression
a. ❒ Speech
b. ❒ Writing messages to express or clarify needs
c. ❒ American Sign Language or Braille
d. ❒ Signs/gestures/sounds
e. ❒ Communication board
f. ❒ Other _____
g. ❒ NONE OF ABOVE

3. Making Self Understood
a. ❒ Understood
b. ❒ Usually understood (difficulty finding words or finishing thoughts)
c. ❒ Sometimes understood (ability is limited to making concrete requests)
d. ❒ Rarely/Never understood

4. Ability to Understand
a. ❒ Understands
b. ❒ Usually understands (may miss part/intent of message)

c. ❒ Understands verbal information
d. ❒ Understands written information
e. ❒ Sometimes understands (responds to simple/direct communication)
f. ❒ Rarely/Never understands

SECTION E: VISION *(Ability to see in adequate light and with glasses if used)*

1. ❒ Adequate (sees fine detail, including regular print in newspapers/books)
❒ Impaired (sees large print, but not regular print in newspapers/books)
❒ Moderately impaired (limited vision; not able to see newspaper headlines, but can identify objects)
❒ Highly impaired (object identification in question, but eyes appear to follow objects)
❒ Severely impaired (no vision or sees only light, colors, or shapes; eyes do not appear to follow objects)
2. If resident uses glasses, is resident able to get his/her glasses without assistance? 1. ❒ Yes 2. ❒ No

SECTION F: MOOD AND BEHAVIOR

1. Indicators of Depression, Anxiety, Sad Mood (Ask the resident)

During this past month:

A. Have you often felt downhearted or blue? 1. ❒Yes 2. ❒No 3. ❒Unable to answer
B. Have you been anxious a lot or bothered by your nerves? 1. ❒Yes 2. ❒No 3. ❒Unable to answer
C. Have you felt hopeless or helpless at all? 1. ❒Yes 2. ❒No 3. ❒Unable to answer
D. Resident Comments:

_____

2. Behavioral Symptoms

(A) Problem behavior (B) Behavioral symptom

0 = behavior not exhibited 0 = Behavior was not present OR easily altered
1 = behavior of this type occurred less than daily 1 = Behavior was NOT easily altered
2 = behavior occurred daily

(A) (B)

a. **Wandering** (moved with no rational purpose, seemingly oblivious to needs or safety)
b. **Verbally aggressive** (others were threatened, screamed at, cursed at)
c. **Physically aggressive** (others were hit, shoved, scratched, assaulted)
d. **Socially inappropriate/disruptive behavior** (made disruptive sounds, noisiness,screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)
e. **Resists care** (resisted taking medications/injections, ADL assistance, or eating)

3. Wandering Risk

A. ❒ Wanders within the residence
B. ❒ Wanders outside, within fenced area
C. ❒ Wanders and attempts to leave building grounds (exit seeking)

D. ❒ Up wandering for all or most of the night
E. ❒ Not Applicable

4. Special Programs for Mood, Behavior and Cognitive Loss

A. ❒ **Behavioral symptom management program:** The resident has an ongoing, comprehensive, interdisciplinary program to evaluate behavioral symptoms. The purpose of such a program is to attempt to understand the "meaning" behind the resident's behavioral symptoms in relation to the resident's health and functional status, and social and physical environment. The ultimate goal of the program is to understand and implement a plan of care aimed at reducing the distressing symptoms.

B. ❒ **Behavioral management program:** The resident has a special program that involves making specific changes in their environment to address mood, behavior, or cognitive patterns. Examples include placing a banner labeled "wet paint" across a closet door to keep the resident from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for a resident who frequently stops wandering to rummage. Also check this item is the resident is involved in resident or group sessions that aim to reduce disorientation in confused residents. This would include reorientation efforts such as environmental cueing in which all staff involved with the resident provide consistent orienting information and reminders.

C. ❒ **Evaluation by a licensed mental health specialist:** Since the last assessment the resident has been seen by a qualified clinical professional (such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker) for assessment of mood, behavior disorder, or some other mental health problem. Do not check this item for routine visits by facility social worker.

D. ❒ **Group therapy:** Resident regularly attends sessions at least weekly. Therapy is aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. The session may take place either at the residence or outside the residence.

F. ❒ NONE OF ABOVE

5. Change in Behavioral Symptoms *(Resident's behavior in last 90 days or as compared to last assessment):*

a. ❒No change b. ❒Improved c. ❒Deteriorated

1. (A) ADL Self-Performance (Code for resident's performance over all shifts during last 7 days-Not including setup. **Code for the most dependent in a 24 hour period.**)

0 = Independent: No help or oversight OR Help/oversight provided only 1 or 2 times during last 7 days

1 = Supervision: Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days

2 = Limited Assistance: Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days

3 = Extensive Assistance: While resident performed part of activity, over last 7 day

period, help of following type(s) provided 3 or more times: Weight bearing support; Full staff performance during part(but not all) of last 7 days

4 = Total Dependence: Full staff performance of activity during entire 7 days

8 = Activity did not occur.

a. BED MOBILITY: How resident moves to and from lying position, turns side to side, and positions body while in bed

b. TRANSFER: how resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)

c. WALK IN ROOM: how resident walks between locations in his/her room

d. WALK IN CORRIDOR: how resident walks in corridor of residence

e. LOCOMOTION IN RESIDENCE: how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair

f. LOCOMOTION OUT OF RESIDENCE: how resident moves to and returns from out of residence locations (e.g. areas set aside for dining, activities, or treatment). If residence has only one floor, how resident moves to and from distinct areas on the floor. If in wheelchair, self-sufficiency once in chair

g. DRESSING: how resident puts on, fastens, and takes off all items of street clothing including donning/removing prosthesis

h. EATING: how resident eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)

i. TOILET USE: how resident uses the bathroom (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothing

j. PERSONAL HYGIENE: how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

k. CLIMBS STAIRS: how resident climbs stairs Code N/A Only if facility does not have stairs

l. BATHING: how resident takes full body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back & hair)

SECTION G: PHYSICAL FUNCTIONING

(B) Support
(A) Self Performance
(B) ADL Support Provided (Code for **MOST SUPPORT PROVIDED OVER ALL SHIFTS** during last 7 days; code regardless of resident's self-performance classification)
0 = No setup or physical help from staff
1 = Setup help only
2 = One person physical assist
3 = Two+ persons physical assist

2. Body Control
a. ❒Bedfast all or most of the time d. ❒Hemiplegia/hemiparesis (weakness/paralysis of 1 side)
b. ❒Quadriplegia e. ❒Amputation
c. ❒Unsteady gait f. ❒NONE OF ABOVE
3. Modes of Locomotion
a. ❒Cane/walker/crutch d. ❒Other person wheeled
b. ❒Wheeled self D. 0 Other person wheeled e. ❒Other:_____
c. ❒Wheelchair primary mode of locomotion f. ❒None of Above
4. Modes of Transfer
a. ❒Bedfast all or most of the time e. ❒Transfer aid (e.g. slide board, trapeze,
b. ❒Lifted manually cane, walker, brace) c. ❒Bed rails used for bed mobility or transfer
f. ❒NONE OF ABOVE
d. ❒Lifted mechanically
5. Self-Performance in ADLs *(Resident's ADL status or abilities in last 90 days or compared to last assessment):*
1. ❒ No change 2. ❒ Improved 3. ❒ Declined
6. Instrumental Activities of Daily Living *(Code for level of independence in the last 30 days based on resident's involvement in the activity).*
A. Self-Performance Codes:
0 = Independent: (With/without assistive devices)—No help provided.
1 = Done with help: Resident involved in activity but needed supervision, reminders, and/or physical help to complete activity.
2 = Done by others: Full performance of the activity is done by others.
B. Support Codes:
0 = No support provided
1 = Supervision/cueing
2 = Set-up only
3 = Physical assistance

Residents Self Performance to:	A. Self Performace	B. Support
a.	Arrange for shopping for clothing, snacks or other incidentals.	
b.	Shop for clothing, snacks, or other incidentals.	
c.	Arrange suitable transportation.	

d.	Manage finances: banking, handling checkbook, or paying bills.
e.	Manage cash, personal needs allowance.
f.	Prepare snacks, light meals.
g	Use phone.
h.	Do light housework, e.g. makes bed, dusts, or takes care of belongings.

7. Self-Performance in IADLs *(Resident's IADL status or abilities compared to last assessment)*
. ❒No change 2. ❒Improved 3. ❒Declined 4. ❒N/A

8. ADL and IADL Functional Rehabilitation or Improvement Potential *(Check all that apply)*
a. ❒Resident believes he/she is capable of increased independence.
b. ❒Direct care staff believe resident is capable of increased independence.
c. ❒Resident able to perform tasks/activity but is very slow.
d. ❒Resident's abilities to perform activities differ or vary from morning to evening.
e. ❒Resident could be more independent if he/she had special equipment (e.g. cane, walker, plate guard).
f. ❒Task segmentation (one or two step directions)
g. ❒Resident would benefit from ADL or IADL skills training.
h. ❒NONE OF ABOVE

9. Skills Training *(Record the number of days, in the last 30 days that the resident received skill training for at least 15 consecutive minutes.)*
a. _____ Meal preparation (snacks, light meals)
b. _____ Telephone use
c. _____ Light housework (makes own be, takes care of belongings)
d. _____ Laundry (sorts, folds, or washes own laundry)
e. _____ Managing incontinence supplies (pads, briefs, ostomy, catheter)
f. _____ Managing cash (handles cash, makes purchases)
g. _____ Managing finances (banking, handling checkbook or savings account)
h. _____ Arranges shopping (makes list, acquires help)
i. _____ Shopping (for groceries, clothes, or incidentals)
j. _____ Transportation (travel by various means to get to appointments or necessary engagements)
k. _____ Medications (preparation and administration of medications)

10. Devices Needed *(Check all that apply)*
Resident expresses or gives evidence of needing new, repaired or additional assistive devices.
a. ❒ Eyeglasses f. ❒ Assistive dressing devices (e.g. button hook)
b. ❒ Hearing aid g. ❒ Dentures
c. ❒ Cane or walker h. ❒ Other: _____
d. ❒ Wheelchair i. ❒ NONE OF ABOVE
e. ❒ Assistive eating devices (e.g. plate guard)

SECTION H: CONTINENCE IN LAST 14 DAYS

0 = CONTINENT: Complete control
1 = USUALLY CONTINENT: Incontinent episodes once a week or less
2 =OCCASIONALLY INCONTINENT: 2 or more times a week but not daily
3 = FREQUENTLY INCONTINTENT: Tended to be incontinent daily, but some control present
4 = INCONTINENT: Inadequate control, multiple daily episodes

1. a. Bladder Continence
Control of urinary bladder function (if dribbles, volume is insufficient to soak through underpants) with appliances used (e.g. pads or continence program employed)

1. b. Bowel Continence
In last 7 days, control of bowel movement, with appliance or bowel continence programs if employed

2. Appliances and Programs *(Check all that apply)*
a. ❒ Scheduled toileting plan f. ❒ Did not use bathroom/commode/urinal
b. ❒ Bladder retraining program g. ❒ Pads/briefs used
c. ❒ External (condom) catheter h. ❒ Enemas/irrigation
d. ❒ Indwelling catheter i. ❒ Ostomy present
e. ❒ Intermittent catheter j. ❒ NONE OF ABOVE

3. Change in urinary continence *(Resident's urinary continence has changed as compared to status of 90 days ago or since last assessment if less than 90 days)*
1. ❒ No change 2. ❒ Improved 3. ❒ Deteriorated 4. ❒ N/A

SECTION I: DIAGNOSIS *(List current diagnoses that are in the resident's record.)*

1. CURRENT DIAGNOSIS:
_____
_____
_____

2. ACTIVE HEALTH CONDITIONS:
a. ❒ Aphasia m. ❒ Quadriplegia
b. ❒ Cerebral palsy n. ❒ Wound infection
c. ❒ Dementia other than Alzheimer's o. ❒ Septicemia
d. ❒ Traumatic brain injury p. ❒ MRSA/VRE Source:_____
e. ❒ Emphysema/COPD q. ❒ Urinary tract infection
f. ❒ Renal failure r. ❒ Recurrent lung aspirations in last 90 days
g. ❒ Pneumonia s. ❒ Shortness of breath
h. ❒ Respiratory Infection t. ❒ Vomiting
i. ❒ Dehydrated; output exceeds input u. ❒ End-stage disease, 6 or fewer months to live j. ❒ Delusions v. ❒ Other:_____
k. ❒ Hallucinations w. ❒ NONE OF THE ABOVE
l. ❒ Internal Bleeding

3. INACTIVE BUT RELEVANT HEALTH CONDITIONS (*List*):
_____

_____

_____

SECTION J: ORAL/NUTRITIONAL STATUS

1. Height:_____ 3. Weight Change in last 30 days: a. ❒ Loss b. ❒ Gain

2. Weight: _____

4. Nutritional Approaches

a. ❒ Parenteral IV e. ❒ Mechanically altered (or pureed) diet

b. ❒ Feeding tube f. ❒ Noncompliance with diet

c. ❒ On a planned weight change program g. ❒ Restrictions (specify)

_____

d. ❒ Therapeutic diet h. ❒ NONE OF ABOVE

5. Dental Status

a. ❒ Debris (soft, easily movable substances) present in mouth prior to going to bed

b. ❒ Has dentures or removable bridges

c. ❒ Some/all natural teeth lost-does not have or does not use dentures (or partial plates)

d. ❒ Broken, loose, or canous teeth

e. ❒ Inflamed gums (gingival; swollen or bleeding gums; oral abscesses; ulcers or rashes)

f. ❒ Daily cleaning of teeth/dentures or daily mouth care- by resident or staff

g. ❒ Chewing or swallowing problem

h. ❒ NONE OF ABOVE

SECTION K: SKIN CONDITION

1. Ulcers *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). (Code 9 = 9 or more) (Completion of this section requires full body exam)*

A. _____ Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

B. _____ Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

C. _____ Stage 3: A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue.

D. _____ Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

2. Type of Ulcer *(For each ulcer, code for the highest stage using scale in item L1 above—e.g. 0 = none; stages 1,2,3,4)*

A. _____ Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue.

B. _____ Stasis ulcer—open lesion caused by poor circulation in the lower extremities.

3. Other Skin Problems or Lesions Present

a. ❒ Abrasions, bruises

b. ❒ Burns (second or third degree)

c. ❒ Rashes, itchiness, body lice, scabs

d. ❒ Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions)

e. ❒ Skin tears or cuts (other than surgical)

f. ❒ Surgical wounds
g. ❒ NONE OF ABOVE

4. Foot Problems

A. Does this resident have any foot problems? 1. ❒ Yes 2.❒ No
B. If foot problems, list type:

_____

5. Skin Treatments

a. ❒Pressure relieving device(s)
b. ❒Turning/positioning program
c. ❒Ulcer and/or wound care
d. ❒Nutrition or hydration intervention
e. ❒Application of dressings (with or without topical medications)
f. ❒Application of ointments/medications
g. ❒Other preventative or protective skin care (i.e. lotion)
h. ❒NONE OF ABOVE

6. Pain Status

A. Does the resident have pain that interferes with ADL's?
1. ❒Yes 2. ❒No
If yes, how often:
a. ❒Less often than daily
b. ❒Daily, but not constantly
c. ❒All of the time
d. ❒Not applicable
0

SECTION L: MEDICATIONS

A. Does the resident take medication? Include over the counter medications. 1. ❒Yes 2. ❒No

If yes, answer the next 4 questions. If no, skip to Special Treatments and Procedures.

B. Does the resident know what the medications are for? 1. ❒Yes 2. ❒No
C. Does the resident know how to take the medications? (proper route) 1. ❒Yes 2. ❒No
D. Does the resident know how often to take the medications? 1. ❒Yes 2. ❒No
E. Does the resident communicate desired effect or unintended side effects? 1. ❒Yes 2. ❒No
F. Does the resident control his/her own prescription medications? 1. ❒Yes 2. ❒No
G. Does the resident control his/her own over-the-counter medications? 1. ❒Yes 2. ❒No
H. Injections: Record the # of days injections of any type received during last 7 days.

_____

A NO response to any question B. through E. indicates the resident needs medication administration.

I. Who gives the injections? *(Choose one)*
1. ❒ Resident 2. ❒ RN or LPN 3. ❒ Unlicensed Staff 4. ❒ Other

_____

J. When was the last time the physician reviewed ALL the resident's medications? *(Choose one)*
. ❒ 1-6 months 2. ❒ 12 months 3. ❒ Over 1 year 4. ❒ Unknown
K. Medication Compliance *(Resident's level of compliance with prescribed medications during last 30 days or since admission.)*

. ❒ Always compliant
2. ❒ Compliant atleast 80% of the time
3. ❒ Rarely or never compliant

L. Record the number of days during the last 7 days any of the following medications were used.

1. ____ Anti-psychotic 3. ____ Anti-depressant 5. ____ Diuretic
2. ____ Anti-anxiety 4. ____ Hypnotic

SECTION M: SPECIAL TREATMENTS, PROCEDURES AND SERVICES

1. Special Treatments, Procedures and Programs

Check treatments or programs received during the last 14 days.

TREATMENTS

a. ❒ Chemotherapy g. ❒ Oxygen therapy
b. ❒ Dialysis h. ❒ Radiation
c. ❒ IV medication i. ❒ Suctioning
d. ❒ Intake/output j. ❒ Tracheostomy care
e. ❒ Monitoring acute condition k. ❒ Transfusions
f. ❒ Ostomy care l. ❒ Ventilator or respirator

2. OTHER PROVIDERS/SERVICES

a. ❒ Alcohol/drug treatment program f. ❒ Day treatment program
b. ❒ Alzheimer's/dementia special care unit g. ❒ Sheltered workshop/employment
c. ❒ Hospice care h. ❒ Transportation
d. ❒ Home health i. ❒ Mental health Services
e. ❒ Area Agency on Aging j. ❒ NONE OF ABOVE

3. Rehabilitative/Restorative Care *(Record the number of days each of the following rehabilitative or restorative techniques or practices was provided to the resident for* ***more than or equal to 15 minutes per day*** *in the last 7 days). Enter 0 if none or less than 15 minutes daily.*

a. _____ Range of motion (passive) g. _____ Dressing or grooming
b. _____ Range of motion (active) h. _____ Eating or swallowing
c. _____ Splint or brace assistance i. _____ Amputation/prosthesis care
d. _____ Bed mobility j. _____ Communication
e. _____ Transfer k. _____ Other (specify)
f. _____ Walking l. _____ NONE OF ABOVE

4. Visiting Nurse/Home Health Therapies

A. Has the resident received care or services from a home health nurse or aide since admission or the most recent assessment? 1. ❒ Yes 2. ❒ No

B. Indicate type of service for all that apply: (i.e.speech therapy)

(a) Less than once a week (b) Once a week (c) More than once/week

1. Nurse _____ _____ _____
2. Nurse aide _____ _____ _____
3. Therapist _____ _____ _____

1. Devices and Restraints *(Codes: 0=not used; 1=used less than daily; 2 = used daily)*

a. _____ Full bed rails on all open sides of bed d. _____ Chair prevents rising
b. _____ Trunk restraint e. _____ Limb restraint

c. _____ Other types of side rails, e.g. half, etc. f. _____
Chemical_____

2. SIGNATURES OF PERSONS INVOLVED IN COMPLETING ASSESSMENT:

A. Person completing assessment *(required if other than RN)*

Signature Title Date

B. Resident or legal representative

Signature Date

C. Facility Registered Nurse *(required)*

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified

Signature Title Date